**§ 9771. Applications for Certification**

(a) Any of the following entities may apply for certification as a health care organization:

(1) A disability insurer licensed by the Department of Insurance to transact health insurance or disability income insurance pursuant to Part 2 of Division 2 of the Insurance Code.

(2) Any workers compensation health care provider organization.

(b) An applicant must meet all of the requirements set forth in this article in order to be certified as a health care organization by the administrative director. Applicants must initially submit to the administrative director, as part of the application, a plan which will provide a clear and concise description of how occupational medical and health care services are to be provided and how each of the requirements in this article are met, and, where specified, in the manner required under each section. HCOs must include all documentation necessary to demonstrate that they meet the requirements for certification.

(c) Health care service plans must provide written certification that at the time of application the applicant is not in violation of any provision of law or rules or orders of the Director of the Department of Managed Health Care, and that there are no outstanding orders, undertakings, or deficiency letters which involve the applicant. Disability insurers must provide written certification that at the time of application they are in good standing with the Department of Insurance. The requirement of this subdivision may be satisfied by verified statement under penalty of perjury by the president or managing officer of an applicant that the applicant meets the requirements of this subdivision, subject to verification by the administrative director.

(d) An applicant who is in compliance with requirements for certification by the Department of Insurance may submit copies of any relevant exhibits, sections or other documents submitted as part of the primary certification application to meet any of the requirements of this article, provided that the applicant (1) verifies that the Department of Insurance has fully reviewed and approved the submitted information, (2) provides a concise narrative identifying any manner in which HCO services will be provided differently from those provided under the primary certification, and (3) provides a concise description for each requirement of this article, specifying how occupational medical and health care services or other services specifically and exclusively required by this article will be met.

(e) Applications must be in writing in the form and manner prescribed by the administrative director, and must be submitted on or after January 1, 1994. The original plus one copy of the application shall be submitted together with a fee as specified in subdivision (c). Each application shall provide, in addition to the plan specified in subdivision (b), the following information:

(1) The names of all directors and officers of the health care organization;

(2) The title and name of the person designated to be the day-to-day administrator of the health care organization.

(3) The title and name of the person designated to be the administrator of the financial affairs of the health care organization.

(4) The name, medical specialty, if any, board certification, if any, and any unrestricted licenses (including states where licensed), of the medical director.

(5) The name, address, and telephone number of a person designated to serve as a liaison for the Division, who is responsible for receiving compliance and informational communications from the Division and for disseminating the same within the HCO organization.

(6) A sample of each type of contract with participating providers, claims administrators, and insurers, and any entities specifically providing services required by this article; and a list of contractors for each type of contract. Copies of contracts shall be made available to the administrative director upon request. The Division will maintain as confidential information pertaining to provider rates and other financial information in accordance with Government Code Section 6254(d)(1).

(7) An organizational chart demonstrating the structural relationships between the medical director, fiscal or financial administrator, and executive officers and administrators.

(8) The identity of any worker's compensation insurer that controls or is controlled by the applicant, as defined by Section 1215 of the Insurance Code.

(f) Each application for certification must be accompanied by a non refundable fee of $ ~~20,000~~ 2,500.

(g) In lieu of an application for certification, an entity licensed as a full service health care service plan under Section 1353 of the Health and Safety Code (a Knox-Keene Health Care Service Plan Act) and deemed to be an HCO pursuant to Labor Code Section 4600.5(c) shall submit to the administrative director:

(1) a concise description of how the health plan will satisfy the requirements of Labor Code Section 4600.5(c)(1 - 5) and Sections 9772 through 9778, inclusive, of these regulations. At the time the materials required by this subsection are submitted to the administrative director for review, the health plan shall pay a nonrefundable documentation processing and review fee of $ ~~10,000~~ 1,000; and,

(2) written certification that the health plan is not in violation of any provisions of law or rules or orders of the Director of the Department of Managed Health Care, and that there are no outstanding orders, undertakings, or deficiency letters which involve the health plan. The requirements of this subdivision

may be satisfied by verified statement under penalty of perjury by the president or managing officer of the health plan that the plan meets the requirements of this subdivision, subject to verification by the administrative director.

Authority cited: Sections 133, 4600.5, 4600.7, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4600 and 4600.5, Labor Code.

**§ 9771.1 Updating Applications**

(a) Every application submitted under Section 9771(e) shall be kept current to reflect accurately the actual operation of the HCO. An applicant or a certified HCO shall file an amendment to its application to show any change in any information contained in the application. Amendments include changes, deletions, additions and variations to the original application and its exhibits, including sample contracts. Amendments shall be filed as set forth in this section. However, the administrative director may approve an alternative form of submitting an amendment if it substantially accomplishes the purposes of this section.

(b) An original and one copy of an amendment shall be submitted to the administrative director as follows:

(1) Submit an Execution Page of the application, indicating it is an "Amendment to Pending Application" or "Amendment to Application of a Certified Organization";

(2) Furnish only those pages of the application and/or those exhibits which are changed by the amendment.

(3) If a page of the application is amended, complete all items on that page and "redline" or otherwise clearly designated the changed item. At the lower left-hand corner of each page, type "Rev. [date]", giving the effective date of the amendment.

(4) If an exhibit is being amended:

(A) Furnish the complete exhibit as amended, bearing the same number as the original exhibit, with the changed portions of the exhibit "redlined" or otherwise clearly designated, or

(B) Furnish the pages of the exhibit which are amended, each page to be marked with the exhibit number and the page number of the exhibit, and with the changed portions "redlined" or otherwise clearly designated. At the lower left-hand corner of each page, type "Rev. [date]", giving the effective date of the amendment. If this method of amendment is employed, the applicant shall refile the entire

exhibit as amended whenever more than 10 percent if its pages have been amended.

(2) In the event that it is impossible to submit a proposed material change in the application 30 days before the change is implemented, the applicant shall submit the change as soon as the applicant becomes aware that a change is required. If, in the opinion of the administrative director, the change or proposed changed raises a question as to the ability of a certified HCO to meet the requirements of this article, the administrative director may, within 30 days of receiving notice of the change inform the HCO of the question. When the administrative director informs the HCO that a question exists, the HCO may not implement the proposed change, or shall cease implementing the change. The HCO may submit whatever materials it deems appropriate to justify the amendment and may meet with the administrative director or staff to discuss the question. Within 30 days after informing the HCO of the question, the administrative director shall inform the HCO whether the amendment is approved or disapproved.

(d) Amendments making non-material changes shall be filed quarterly on dates specified by the administrative director. However, a list of providers need be amended only when 10 percent or more of the names contained in the list for a service area have been changed or when the sole or principal provider for a particular health care service in a service area is added or deleted. When amended, the complete list (or the list for the service area) shall be furnished following the instructions for the particular item, with each added "redlined" or otherwise clearly designated and the names of persons deleted from the list shown at the end under the heading "deletions."

(e) Review of amendments submitted under section 9771.1, except quarterly updates under section 9771.1(e)(2), will be charged based on the actual cost for performing the review. The amount shall include the actual salaries or compensation paid to the persons reviewing amendment; the expenses incurred in the course thereof, and overhead costs in connection therewith as fixed by the Administrative Director. Overhead costs shall be based on the total expenditure for operating expenses and equipment, except travel, of the managed care unit of the Division of Workers' Compensation for the previous fiscal year. The invoice will be sent upon the completion of the review and shall be paid within 30 calendar days.

Authority: Sections 133, 4600.5, 4600.7, 5307.3, Labor Code.

Reference: Sections 4600.3, 4600.5, Labor Code.

**§ 9771.80. Additional or Nonroutine Examinations and Surveys**

(a) An examination or survey is additional or nonroutine for good cause for the purposes of Section 4600.6(q) of the Code when the reason for such examination or survey is any of the following:

(1) The organization's noncompliance with written instructions from the Administrative Director;

(2) The organization has violated, or the Administrative Director has reason to believe that the organization has violated, any of the provisions of Sections 4600.3, 4600.5, or 4600.6 of the Code or regulations referring to those sections.

(3) The organization has committed, or the Administrative Director has reason to believe that the organization has committed, any of the acts or omissions enumerated in Section 4600.5(k) of the Code.

(4) The Administrative Director deems such additional or nonroutine examination or survey necessary to verify representations made to the Administrative Director by an organization in response to a deficiency letter.

(b) Each situation giving rise to an additional or nonroutine examination or survey shall be evaluated on a case-by-case basis as to the seriousness of the violation, or lack of timely or adequate response by the organization to the Administrative Director's request to correct the violation. The organization shall be notified in writing of the provisions of the Act or regulations which have been, or may have been, violated and which therefore caused such additional or nonroutine examination or survey to be performed. The expense of such examinations and surveys shall be charged to the organization being examined or surveyed in accordance with Section 4600.6(q) of the Code.

Authority cited: Stats. 1997, Ch. 346, Section 5.

Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

**§ 9778. Evaluation**

(a) The HCO must include a timely and accurate method to report to the administrative director the following information, in a standardized format to be prescribed by the administrative director:

(1) ~~Cost of services under the plan, specific to particular industries and occupations, diagnoses, and procedures.~~

~~(2)~~ Aggregated information on the number of HCO enrollees and their age, sex, geographical distribution, occupation, and SIC, by federal employer identification number.

~~(b) The HCO shall provide the following information on each injured enrollee.~~

~~i. For HCO enrollee claims opened in the calendar year:~~

~~(1) Patient's Employer's Federal Identification Number and SIC code.~~

~~(2) Injured enrollee name, date of birth, gender, social security number, and occupation.~~

~~(3) Date of injury.~~

~~(4) Diagnosis (ICD-9).~~

~~ii. For HCO enrollee claims closed during a calendar year, the following information linked with enrollee name, date of birth, and social security number:~~

~~(5) Medical Treatment, including dates of surgery and hospitalization.~~

~~(6) Date injured HCO enrollee released to return to work by the primary treating physician.~~

~~(7) Date injured HCO enrollee actually returned to work (not "released to work").~~

~~(8) HCO enrollee's job status at time of return to work (full or modified duty, or job different from pre-injury job), and employee's job status, including no longer employed, at time of close of claim.~~

~~(9) Permanent Disability rating.~~

~~(10) Whether injured HCO enrollee was represented by an attorney at any time through the claims process.~~

~~(c) Effective March 1, 2000, data elements required pursuant to paragraph (b) may instead be provided to the administrative director directly by the claims administrator in the format specified in Article 1.1 (commencing with section 9700), provided that:~~

~~(1) The claims administrator provides the data for all injured HCO enrollees for whom it contracts for medical care; and~~

~~(2) The HCO provides to the administrative director all information required by this section which is not provided by the claims administrator.~~

(2) Information required to be provided pursuant to this section ~~on claims opened and closed in the previous calendar year~~ shall be made available by the HCO to the administrative director, in a form and manner to be prescribed by the administrative director, annually, on March 1~~, commencing with March 1, 1995~~.

(b) Information regarding medical and health care service cost and utilization, rates of return to work, and average time in medical treatment shall be submitted by the claims administrator in the format

specified in Article 1.1 (commencing with section 9700).

Authority cited: Sections 133, 4600.5, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4600 and 4600.5, Labor Code.

**§ 9779. Certification**

(a) Once an applicant has completed an application and submitted a fee in accordance with Section 9771 and has demonstrated to the administrative director that its organization has met all of the criteria for certification, the administrative director will certify the organization as an HCO for a period of three years, unless earlier revoked or suspended.

(b) Once the Administrative Director has determined that an entity licensed as a full service health care service plan under Section 1353 of the Health and Safety Code (a Knox-Keene Health Care Service Plan Act) and deemed to be an HCO pursuant to Labor Code Section 4600.5(c) has complied with the requirements of Section 9771 subsections (g)(1) and (2) the administrative director shall certify the organization as an HCO, pursuant to Section 4600.5(c), for a period of three years unless earlier revoked or suspended.

(c) A certification shall state that a particular entity is certified as a health care organization to provide health care to injured employees for injuries and diseases and other services in accordance with the terms of the entity's application. The certification shall also state: (1) the geographic service area in which the health care organization is permitted to provide health care, (2) the maximum number of enrollees, (3) the name or names under which the health care organization is permitted to provide health care, (4) the date of expiration of the certification, and (5) any other conditions or limitations.

(d) The HCO will be recertified at the expiration of each subsequent three year period, provided it continues to meet the requirements of this article and timely pays a recertification fee of $ ~~10,000~~ 1,000.

Authority cited: Sections 133. 4600.5. 4600.7, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4600, 4600.5 and 4600.7, Labor Code.

**§ 9779.1. On-Site Surveys**

(a) The HCO must ensure that it will be available for and cooperate with on-site surveys as the administrative director deems necessary to insure compliance with this article, including during the initial certification process. The administrative director will coordinate on-site surveys with the

Department of Managed Health Care to the extent feasible.

(b) The administrative director will notify the HCO of deficiencies found by the survey team. The administrative director will provide the HCO a reasonable time to correct the deficiencies. Failure on the part of the HCO to timely correct noted deficiencies may result in suspension or revocation of an HCO's certification in accordance with Section 9779.2.

(c) Reports of all surveys shall be open to public inspection, except that no survey shall be made public unless the HCO has had an opportunity to review the survey and file a statement in response within 30 days, to be attached to the report. Deficiencies shall not be made public if they are corrected within 30 days of the date that the HCO was notified.

(d) Non-routine audits will be charged based on the actual cost for performing the audit. The amount shall include the actual salaries or compensation paid to the persons making the audit, the expenses incurred in the course thereof, and overhead costs in connection therewith as fixed by the Administrative Director. Overhead costs shall be based on the total expenditure for operating expenses and equipment, except travel, of the managed care unit of the Division of Workers' Compensation for the previous fiscal year. The invoice will be sent upon the completion of the audit and shall be paid within 30 calendar days.

Authority cited: Sections 133. 4600.5. 4600.7, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4600, 4600.5 and 4600.7, Labor Code.

**§ 9779.5 Reimbursement of Costs to the Administrative Director; Obligation to Pay Share of Administrative Expense**

(a) Each organization certified under this article shall pay to the administrative director an amount as estimated by the administrative director for the ensuing fiscal year, as a reimbursement of a share of all costs and expenses, including routine on-site surveys, data collection and dissemination and overhead, reasonably incurred in the administration of this article and not otherwise recovered by the administrative director under this article or from the Worker's Compensation Managed Care Fund. The amount shall be assessed annually on or before April 15 and may be paid to the Workers' Compensation Managed Care Fund in two equal installments. The first installment shall be paid on or before July 1 of each year and the second installment shall be paid on or before December 15 of each year.

(1) Annual Assessment: The assessment shall be calculated on the basis of the number of enrollees in each individual HCO. ~~Each HCO will be assessed a sum equivalent to $ 1.00 per enrollee,~~ bBased on the number of enrollees enrolled in the HCO on December 31 of the prior calendar year~~.~~, the annual assessment shall be $250.00 for 0 to 1000 enrollees, $350 for 1001 to 5000 enrollees, and $500 for 5001

or more enrollees.

~~(2) Loan Repayment Surcharge: Each HCO will be assessed an annual surcharge of fifty cents per enrollee, based on the number of enrollees in the HCO on December 31 of the prior calendar year, until the loan is fully repaid. This surcharge will be used solely to reimburse the general fund for the loan made to the Workers' Compensation Managed Care Fund. The surcharge shall be assessed at this level for up to five years, commencing with the 1999 assessment. If the general fund loan has not been fully repaid after five years, the annual surcharge for each HCO shall be adjusted the following three years to fully repay the loan as follows:~~

~~2004: (One-third of outstanding loan balance) divided by (total number of enrollees in all certified HCOs) times (number of enrollees in HCO)~~

~~2005: (One-half of outstanding loan balance) divided by (total number of enrollees in all certified HCOs) times (number of enrollees in HCO)~~

~~2006: (Total outstanding loan balance) divided by (total number of enrollees in all certified HCOs) times (number of enrollees in HCO)~~

(b) Non-routine audits conducted in response to complaints will be charged based on the actual cost for performing the audit. The invoice will be sent within sixty days of the completion of the audit and shall be paid within 30 calendar days after the billing date.

(c) In no case shall the reimbursement, payment, or other fee authorized by this section exceed the cost, including overhead, reasonably incurred in the administration of this article.

Authority cited: Sections 133, 4600.5, 4600.7, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4600 and 4600.5, Labor Code.

**~~§ 9779.9 Late Payment~~**

~~Failure to pay fees and assessments within sixty days after the date due pursuant to this section shall allow the administrative director to charge a late payment fee for any outstanding amount at a rate of ten percent after sixty days or one hundred dollars, whichever is greater. In addition, after sixty days a late fee of ten percent per year shall be assessed on any outstanding amount. In addition, the administrative director may suspend or revoke certifications of HCOs which fail to pay fees and assessment in a timely manner.~~

~~Authority: Sections 133, 4600.5, 4600.7, 4603.5, 5307.3, Labor Code.~~

~~Reference: Sections 4600, 4600.5, Labor Code.~~